

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2024
NAME OF PROVIDER OR SUPPLIER  Centre Care Rehabilitation and Wellness Services		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Persia Road Bellefonte, PA 16823	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18229</p> <p>Based on observation, as well as staff and resident interviews, it was determined that the facility failed to ensure self-determination for resident's choices related to wake time schedules for 21 of 34 residents sampled (Residents 1, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 29, 30, and 31).</p> <p>Findings include:</p> <p>Clinical record review for Resident 1 revealed a diagnosis list that included dementia (a loss of cognitive function that is caused by the permanent damage or death of the brain's nerve cells, or neurons) and a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated March 11, 2024, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 7, which indicated severe cognitive impairment.</p> <p>Clinical record review for Resident 9 revealed a diagnosis list that included dementia and a significant change MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 99, which indicated the resident was unable to complete the assessment interview. The MDS further noted the resident's cognitive skills for daily decision making were assessed as moderately impaired.</p> <p>Clinical record review for Resident 10 revealed a diagnosis list that included dementia and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as rarely/never understood and severely impaired in cognitive skills for daily decision making.</p> <p>Clinical record review for Resident 11 revealed a diagnosis list that included dementia and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 99, which indicated the resident was unable to complete the assessment interview. The MDS further noted the resident's cognitive skills for daily decision making were assessed as moderately impaired.</p> <p>Clinical record review for Resident 12 revealed a diagnosis list that included dementia and an annual MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 99, which indicated the resident was unable to complete the assessment interview. The MDS further noted the resident's cognitive skills for daily decision making were assessed as moderately impaired.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review for Resident 13 revealed a diagnosis list that included dementia and an admission MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 99, which indicated the resident was unable to complete the assessment interview. The MDS further noted the resident's cognitive skills for daily decision making were assessed as moderately impaired.</p> <p>Clinical record review for Resident 14 revealed a diagnosis list that included dementia and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 5 which indicted severe cognitive impairment.</p> <p>Clinical record review for Resident 16 revealed a diagnosis list that included dementia and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 7, which indicated severe cognitive impairment.</p> <p>Clinical record review for Resident 17 revealed a diagnosis list that included dementia and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 99, which indicated the resident was unable to complete the assessment interview. The MDS further noted the resident's cognitive skills for daily decision making were assessed as moderately impaired.</p> <p>Clinical record review for Resident 18 revealed a diagnosis list that included dementia and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 15 which indicated no cognitive impairment.</p> <p>Clinical record review for Resident 19 revealed a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 99, which indicated the resident was unable to complete the assessment interview. The MDS further noted the resident's cognitive skills for daily decision making were assessed as severely impaired.</p> <p>Clinical record review for Resident 20 revealed a diagnosis list that included dementia and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 7, which indicated severe cognitive impairment.</p> <p>Clinical record review for Resident 21 revealed a diagnosis list that included dementia and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 99, which indicated the resident was unable to complete the assessment interview. The MDS further noted the resident's cognitive skills for daily decision making were assessed as moderately impaired.</p> <p>Clinical record review for Resident 22 revealed a diagnosis list that included dementia and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 99, which indicated the resident was unable to complete the assessment interview. The MDS further noted the resident's cognitive skills for daily decision making were assessed as moderately impaired.</p> <p>Clinical record review for Resident 23 revealed a diagnosis list that included dementia and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as rarely/never understood and severely impaired in cognitive skills for daily decision making.</p> <p>Clinical record review for Resident 24 revealed a quarterly MDS dated [DATE], that noted facility staff assessed the resident as rarely/never understood and severely impaired in cognitive skills for daily decision making.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review for Resident 26 revealed a diagnosis list that included Alzheimer's Disease (a type of dementia that causes problems with cognitive functioning) and an admission MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 8, which indicated moderate cognitive impairment.</p> <p>Clinical record review for Resident 27 revealed a diagnosis list that included mild cognitive impairment and a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 11 which indicated moderate cognitive impairment.</p> <p>Clinical record review for Resident 29 revealed a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 9, which indicated moderate cognitive impairment.</p> <p>Clinical record review for Resident 30 revealed a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 9, which indicated moderate cognitive impairment.</p> <p>Clinical record review for Resident 31 revealed a quarterly MDS dated [DATE], that noted facility staff assessed the resident as having a BIMS of 10, which indicated moderate cognitive impairment.</p> <p>Observation of the facility on April 9, 2024, starting at 5:30 AM revealed there were residents on [NAME] Court, [NAME] Way, [NAME], and [NAME] Nursing units up and dressed for the day.</p> <p>Observation of the [NAME] Court Nursing Unit on April 9, 2024, from 5:32 to 5:52 AM revealed Residents 9, 10, 11, 12, 13, 14, 16, and 17 were up and dressed for the day. Attempts to interview the residents regarding their wake time preferences were unsuccessful due to their cognitive status. There was no documentation noted in these residents' clinical records that an early wake time was part of the resident's normal routine or was discussed with their responsible parties.</p> <p>Observation of the [NAME] Court Nursing Unit on April 9, 2024, at 5:32 AM revealed that most of the lights, which included hallway and resident room lights were turned on.</p> <p>Interview with Employee 5 (nurse aide) working the 11:00 PM to 7:00 AM shift revealed that they do what they can and start getting residents up around 5:00 AM.</p> <p>At 5:48 AM Employee 6 (nurse aide) was observed in Resident 14's room asking the resident if he wanted to get up for breakfast. Resident 14's light in his room was on at the time.</p> <p>Observation of the [NAME] Way Nursing Unit on April 9, 2024, at 5:55 AM revealed Residents 18, 19, 20, 21, 22, 23, and 24 were up and dressed for the day. Attempts to interview the residents (except Resident 18) regarding their wake time preferences were unsuccessful due to their cognitive status. There was no documentation noted in these residents' clinical records that an early wake time as part of the resident's normal routine was discussed with their responsible parties.</p> <p>Interview with Employee 7 (nurse aide) working the 11:00 PM to 7:00 AM shift confirmed that she is expected to get certain residents up and provide them morning care. Observation of the staff work area on [NAME] Way with Employee 7 revealed an 11-7 Get Up List with 16 residents listed.</p> <p>Interview with Resident 18 on April 19, 2024, at 10:18 AM revealed that she does not want to get up before 7:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of the [NAME] Way Nursing Unit on April 9, 2024, at 6:11 AM revealed Residents 1, 26, 27, and 29 were up and dressed for the day. Attempts to interview the residents related to their wake time preferences were unsuccessful due to their cognitive status. There was no documentation noted in the residents' clinical records that an early wake time was part of the resident's normal routine or was discussed with their responsible parties.</p> <p>Interview with Employee 8 (nurse aide) working the 11:00 PM to 7:00 AM shift confirmed that she is expected to get certain residents up and provide them morning care. Observation of the staff work area on [NAME] (low hall) with Employee 8 revealed an 11-7 Get Up List with 5 residents listed.</p> <p>Observation of the [NAME] Nursing Unit on April 9, 2024, at 6:18 AM revealed Residents 30 and 31 were up and dressed for the day. Attempts to interview the residents regarding their wake time preferences were unsuccessful due to their cognitive status. There was no documentation noted in the residents' clinical records that an early wake time was part of the resident's normal routine or was discussed with their responsible parties.</p> <p>Interview with Employee 9 (nurse aide) working the 11:00 PM to 7:00 AM shift confirmed that the administration expects her to get certain residents up and ready for the day. She stated the residents are listed on their assignment sheets. She indicated there are two separate lists of residents to get up depending on the day of the week.</p> <p>These findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on April 9, 2024, at 10:57 AM</p> <p>The facility failed to promote and facilitate residents' self-determination related to wake times for Residents 1, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 29, 30, and 31.</p> <p>28 Pa. Code 201.29 (a) Resident rights</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</b></p> <p>Based on observations and staff interview, it was determined that the facility failed to properly store, secure, and label resident medications and biologicals on two of five nursing units (Rose Nursing Unit and [NAME] Nursing Unit, Residents 6 and 8).</p> <p>Findings include:</p> <p>Observation of the [NAME] Nursing Unit on April 9, 2024, at 5:50 AM revealed a tube of Calmoseptine (a topical medication used to treat various skin conditions) labeled with Resident 8's name in a corner staff seating area just off the main hallway. There were no staff observed in the area at the time and the tube was easily accessible to anyone passing by.</p> <p>Observation of the [NAME] Nursing Unit on April 9, 2024, at 5:55 AM revealed a tube of Calmoseptine labeled with Resident 6's name unsecured on top of a treatment cart in the hallway outside of resident rooms. A concurrent interview with Employee 3, licensed practical nurse, revealed that the medication should be secured in the treatment cart.</p> <p>Observation of the [NAME] Nursing Unit wound treatment cart on April 9, 2024, at 6:30 AM with Employee 4, licensed practical nurse, revealed a partially used tube of Calmoseptine with no name label on it. Employee 4 stated the unlabeled tube of medication should be disposed of and proceeded to remove it from the cart.</p> <p>An interview with the Director of Nursing on April 9, 2024, at 9:30 AM revealed the tubes of Calmoseptine should be labeled and secured in the treatment carts.</p> <p>The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 9, 2024, at 10:45 AM.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</b></p> <p>Based on observation, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection regarding transmission-based precautions on one of five nursing units ([NAME] Nursing Unit; Resident 1).</p> <p>Findings include:</p> <p>Review of the policy entitled, Linens - Isolation, noted that staff will place dirty linens of any resident on barrier precautions in a yellow laundry bag and it will be tied. This will prevent potentially contaminated linens or laundry from being carried out into the hallway before being placed in a dirty linen hamper. Staff, wearing gloves, will take the used yellow bags out of the resident's room and immediately place the yellow bags in the linen chute located in the dirty utility rooms. Staff will then remove their gloves and wash their hands immediately after handling these potentially contaminated linens/yellow bags.</p> <p>Review of the policy entitled, Infection Control Transmission-Based Precautions, noted that when a resident or unit is placed on transmission-based precautions, appropriate notification is placed on the room or unit entrance door so that personnel and visitors are aware of the need for and type of precaution. The signage informs staff of the type of Centers for Disease Control and Prevention (CDC) precaution(s), instructions for the use of personal protective equipment (PPE), and/or instructions to see a nurse before entering the room. The policy further noted under the section, Contact Precautions, that PPE including a gown and gloves is utilized before or upon entering the room and removed prior to leaving the resident room.</p> <p>Review of the Centers for Disease Control and Prevention (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, last updated July 2023, noted the type of precautions utilized for ESBL (Extended Spectrum Beta-Lactamase, a difficult to treat infection that is resistant to certain types of antibiotics) infections included Contact + Standard.</p> <p>Clinical record review for Resident 1 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated March 11, 2024, that assessed the resident as having a BIMS (Brief Interview for Mental Status) of 7, which indicated cognitive impairment. The MDS assessment noted the resident is dependent for toileting hygiene, has no indwelling catheter, and is frequently incontinent of urine.</p> <p>A current physician's order dated August 9, 2022, noted Contact Precautions: ESBL urine.</p> <p>The last urine culture and sensitivity for Resident 1 was dated September 1, 2023, and indicated it was positive for ESBL. The physician ordered the antibiotic Augmentin 875 mg (milligrams) twice a day for 7 days for the UTI (urinary tract infection). According to an email dated April 10, 2024, at 2:35 PM, the Director of Nursing stated the physician believes the resident is colonized and will always test positive for ESBL.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current care plan revealed Resident 1 has ESBL in the urine and some interventions instructed: bag and transport used linen according to facility protocol, preventing skin exposure or contamination; CONTACT ISOLATION: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry.</p> <p>A review of the Kardex (documentation for nursing staff that refers to pertinent resident care areas and specifics) for Resident 1 revealed, CONTACT ISOLATION: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry.</p> <p>Observation of Resident 1's room on April 9, 2024, at 6:00 AM revealed a sign on the door frame that indicated a resident in the room was on contact precautions. The sign noted Contact Precautions (in addition to Standard Precautions). The sign instructed visitors to stop and report to the nurse before entering. The sign also indicated the following PPE: Gloves (Don gloves upon entry into the room or cubicle. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient. Remove gloves before leaving patient room.); and Gowns (Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the patient care environment.). A tote was observed hanging on the door that included protective gowns and gloves.</p> <p>Further observation from the hallway on April 9, 2024, at 6:00 AM of Resident 1's room revealed Employee 1 (nurse aide) could be heard assisting the resident in the bathroom just inside the door of the room. Employee 1 was observed leaving the bathroom with no gown and only gloves. Employee 2 was also observed at that time entering the room with no gown and later exiting.</p> <p>Observation of Employee 1 on April 9, 2024, at 6:08 AM revealed Employee 1 exited the room with only gloves and no gown and holding various linens that were discarded in a blue linen bag located on a linen cart in the shared hallway.</p> <p>Upon surveyor questioning, both Employees 1 and 2 were unclear if the resident was on contact precautions and if a gown was needed for care. They instructed the surveyor that it should say on the sheet. Employee 2 indicated it was a care sheet with care instructions for the residents. However, upon checking this sheet, Employee 2 noted, it doesn't say. Employee 2 proceeded to ask Employee 3 (license practical nurse) who was nearby passing medications if the resident was on isolation and Employee 3 confirmed the resident is on isolation for ESBL in the urine.</p> <p>A follow-up interview with Employee 1 on April 9, 2024, at 6:41 AM regarding the earlier observations revealed that she was assisting Resident 1 in the bathroom with urinating. Employee 1 also confirmed disposal of the linens in the blue bag and advised they should have gone in a yellow bag.</p> <p>The above information for Resident 1 was reviewed with the Nursing Home Administrator and Director of Nursing on April 9, 2024, at 10:45 AM.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p>		